Department of Health

health

Specialist clinics in Victorian public hospitals

A resource kit for MBS-billed services

State Government Victoria

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Authorised by the State Government of Victoria, 50 Lonsdale Street, Melbourne.

Printed on sustainable paper by PMI Corporation, 400 George Street, Fitzroy 3065

February 2011 (1102006)

Contents

1. Introduction

There is a long history of Medicare Benefits Scheme (MBS)-billed outpatient services (specialist clinics) being provided in public hospitals across Australia.

This resource kit provides information to assist Victorian public hospitals in making decisions about the establishment of MBS-billed specialist clinic services and implementing best practice arrangements in the operation of these clinics. The resource kit is an updated version of the document published by the Victorian Government in June 2008. The current version has been produced in the context of a new agreement between the Commonwealth Government and state/territory governments: The National Healthcare Agreement replaced the Australian Health Care Agreement 2003–2008 on 1 July 2009.

The revised resource kit contains additional information on the costs and benefits of providing MBS-billed specialist clinics in public hospitals, based on the experience of Victorian health services. The inclusion of this information responds to a recommendation of the Victorian Auditor General in the 2008 report, *Private practice arrangements in health services*, and is intended to assist health services in developing business cases for MBS services.

Information on the following topics is included:

- Specialist clinic services in Victoria
- Victorian Ambulatory Classification and Funding Schedule (VACS)
- Medicare Benefits Schedule (MBS)
- *Health Insurance Act 1973*
- National Healthcare Agreement
- Medical remuneration models
- Costs and benefits of MBS-billed specialist clinics
- Medical indemnity.

The document also provides links to further information on these topics, including relevant hospital circulars issued by the Victorian Department of Health.

It is the responsibility of individual health services to ensure that they comply with the requirements of the MBS, the Health Insurance Act, the National Healthcare Agreement and other relevant Commonwealth and state government documents.

The types of specialist clinics and the methods of providing these services differ between public hospitals; therefore, the information provided in this resource kit may not apply in full to all specialist clinic services in Victoria. The document outlines key policy and legislative requirements relating to the operation of MBS-billed specialist clinics in public hospitals. However, health services may require their own legal, financial and/or industrial advice about how these requirements should be met in practice.

2. Specialist clinic services in Victoria

Victorian public health services are responsible for providing inpatient and ambulatory care services in hospital and community-based settings. Specialist clinics provided by public hospitals are part of the continuum of care for patients, and are an important interface in the health system between acute inpatient and primary care services.

Specialist clinics provide planned non-admitted services that require the focus of an acute setting to ensure the best outcome for a patient. They provide access to:

- medical, nursing and allied health professionals for assessment, diagnosis and treatment
- ongoing specialist management of chronic and complex conditions in collaboration with community providers
- pre- and post-hospital care
- maternity care
- related diagnostic services such as pathology and imaging.

Patients are referred to specialist clinics by general practitioners (GPs) and other community-based healthcare providers, as well as specialists and clinicians in emergency departments, inpatient units and other areas of the hospital.

The Victorian Ambulatory Classification and Funding System (VACS)

Most public specialist clinic services in Victoria are funded through VACS. This is an output-based funding system for public hospital specialist clinic services that was introduced in 1997. At present, VACS is used to fund specialist clinic services in 19 public hospitals. Hospitals that do not receive VACS are funded through a non-admitted grant.

VACS funding is based on 35 weighted medical and surgical clinical specialties, and 11 unweighted allied health specialties. Funding is allocated on the basis of annual targets that are set by the Victorian Department of Health.

The VACS funding model comprises five main elements:

1. **Variable grants for medical, surgical and maternity clinical services.** These are determined by the number of patient encounters.
2. **Variable grants for allied health occasions of service.**
3. **Base grants** to cover the fixed costs associated with the provision of outpatient services, such as telephone calls and administration.
4. **Teaching grants**, provided in recognition of clinical teaching that takes place in public hospitals.
5. **Specified grants**, which are provided for highly specialised services.

Policy context

The Victorian and Commonwealth Governments share responsibility for funding public hospital specialist clinic services under the National Healthcare Agreement.

The Victorian Government's ongoing commitment to the provision of public specialist clinics is evidenced by the growth in the level of funding allocated to these services. Figure 1 shows the growth in the level of public specialist clinic funding under VACS from 2003-04 to 2009-10. Figure 2 shows the growth in VACS-funded activity.

Figure 1: Trends in Victorian Government funding of public hospital specialist clinics services, 2003-04 to 2009–10

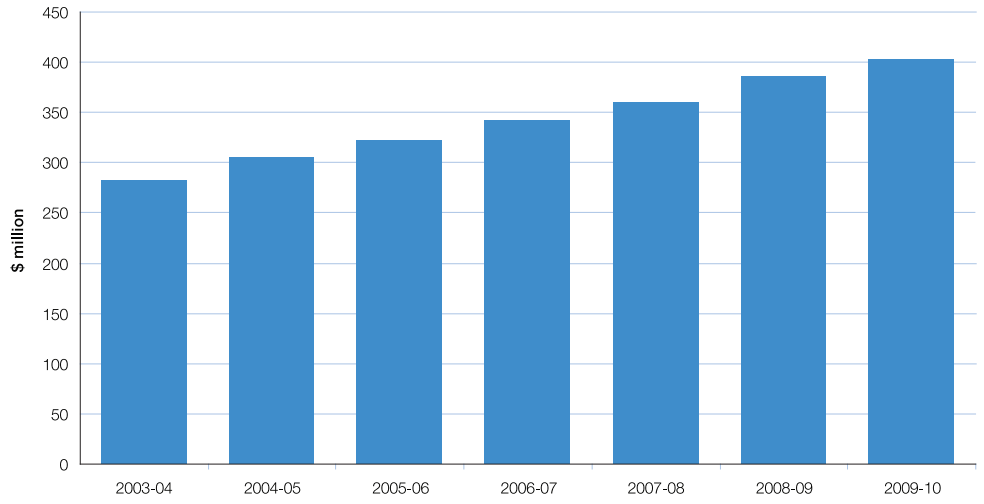
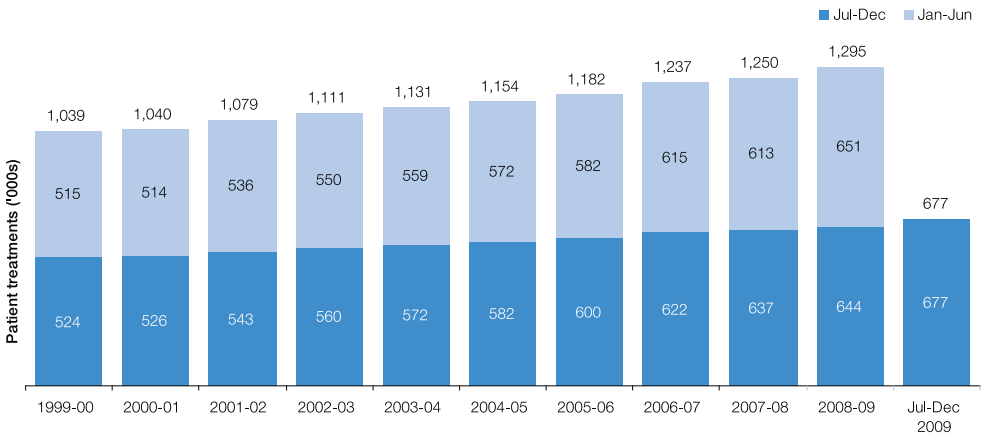


Figure 2: Trends in public hospital specialist clinic services, 1999-2000 to 2008-09



The *Victorian public hospital specialist clinics strategic framework*, published in February 2009, provides policy direction for the planning, organisation and delivery of public hospital specialist clinic services in Victoria. The three objectives of the framework are to ensure timely access, patient focus and sustainable services.

3. Overview of legislation and agreements

Medicare Benefits Schedule

The Medicare system was introduced by the Commonwealth Government in 1984 to provide eligible Australian residents with affordable and high quality medical, optometric and public hospital care.

The MBS lists the professional services for which a Commonwealth-funded payment can be claimed against the Medicare system. Each professional service is associated with a unique item number, service description, schedule fee and benefit payable. The types of services in the MBS are reviewed and amended annually.

The MBS outlines the item number, service description, schedule fee and benefit for each professional service that can be claimed against the Medicare system.

The MBS can be accessed at: http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-benefits-schedule-MBS-1

Health Insurance Act

The *Health Insurance Act 1973*, as amended, governs the payment of MBS benefits.

The Act can be accessed at: www.austlii.edu.au/au/legis/cth/consol_act/hia1973164/

National Healthcare Agreement

The National Healthcare Agreement defines the roles and responsibilities that guide the Commonwealth and states and territories in the delivery of services across the health sector, including public hospital services.

The National Healthcare Agreement can be accessed at:
http://www.coag.gov.au/intergov_agreements/federal_financial_relations/index.cfm

4. MBS-billed specialist clinic services in public hospitals

The Commonwealth Government funds medical practitioners working in a private capacity through the MBS. This funding also extends to medical practitioners exercising a right of private practice within public hospitals. This right to private practice is conferred on medical staff under the terms of their own individual employment contract.

There is a long history of MBS-billed specialist clinics being located in public hospitals across Australia. In general these services are bulk billed against the relevant item number in the MBS, meaning that there is no additional charge to the patient. A co-payment may be charged by specialist medical practitioners providing services in their private rooms, which may be located at a public hospital under a tenancy arrangement.

The requirements for item numbers that stipulate 'personal attendance' must be met by medical practitioners exercising a right of private practice. Junior medical staff do not have rights of private practice in public hospitals; therefore all consultations that are billed against the MBS must include face-to-face time between the patient and the billing medical practitioner.

There are many reasons why MBS-billed specialist clinics have been established in, or near, public hospitals. These include:

- providing patients with a choice of receiving treatment as a public or private[1] patient
- enabling medical practitioners to exercise a right of private practice, which is an important tool in recruiting and retaining a skilled medical workforce for public hospitals
- the co-location of MBS-billed specialist clinics with public hospitals ensures a critical mass of specialist services, and can also help to promote more cost-effective use of high-cost technology and support services
- locating MBS-billed specialist clinics at, or near, public hospitals can assist public hospitals to have available medical practitioners who are able to provide inpatient and outpatient services. It can also broaden the training opportunities for junior medical staff.

Therefore, while the State Government's VACS funding (see page 2) covers the majority of specialist clinic activity in Victorian hospitals, MBS-funded clinics may also be established.

Public hospitals are not required to physically separate the location of VACS-funded and MBS-billed specialist clinics. It is however important that signage informing patients as to whether a clinic is public, private or mixed should be clearly visible. For mixed clinics, signage should indicate that patients have a choice to be treated as either a public or private (MBS-billed) patient. This is important in meeting the requirements of the National Healthcare Agreement relating to informed patient choice and consent to be treated as a private patient (see page 8).

1 For the purpose of this document, a private patient is an eligible person who has elected to receive services that are delivered by a specialist clinician exercising a right of private practice and where services are billed against the MBS.

5. Implications of the Health Insurance Act

It is the responsibility of public hospitals and medical practitioners that provide MBS-billed specialist clinic services to comply with the *Health Insurance Act 1973,* as amended.

A key clause of the Act for medical practitioners exercising a right of private practice within public hospitals is section 19(2), which states:

> Unless the Minister otherwise directs, a Medicare benefit is not payable in respect of a professional service that has been rendered by, or on behalf of, or under and arrangement with:
> (a) the Commonwealth
> (b) a State
> (c) a local governing body or
> (d) an authority established by a law of the Commonwealth, a law of the State or a law of an internal Territory.

The Victorian Department of Health notes advice from the Commonwealth Department of Health and Ageing which states that professional services rendered by a medical practitioner pursuant to his or her right of private practice would be rendered under a contract between the practitioner and the patient, and not by, for, or on behalf of or under an arrangement with the government or statutory authority that has conferred or agreed the right of private practice.

The *Health Insurance Act 1973* is Commonwealth legislation. The Victorian Department of Health therefore considers advice from the Commonwealth Government as definitive and as such medical practitioners exercising rights of private practice in public hospitals does not constitute a breach of section 19(2) of the Act.

6. Implications of the National Healthcare Agreement

The Commonwealth and state and territory governments are obliged to comply with the requirements of the National Healthcare Agreement.

Victorian health services are incorporated public statutory authorities under the *Health Services Act 1988* and are governed by boards. In accordance with the Act, public hospitals and health services are positioned at arms-length from the Victorian Government and have separate legal status.

Corporate and clinical governance of Victorian public hospitals and health services rests with their board. The board is accountable to the government and the community for service delivery activity and outcomes, and prudent expenditure of public funds. Based on this, it is also the responsibility of public hospitals and medical practitioners that provide MBS-billed specialist clinic services to comply with the requirements of the National Healthcare Agreement.

The following requirements of the National Healthcare Agreement should be equally considered by public hospitals and medical practitioners that provide MBS-billed specialist clinic services:

Accessibility of specialist clinic services

Responsibilities of States and Territories 25(a)

Under this part of the National Healthcare Agreement, the States and Territories will:

(a) provide public patients with access to all services provided to private patients in public hospitals.

It is a requirement that, for services where there is a demonstrated clinical need, public hospital services available to private patients should also be accessible to public patients free of charge (i.e with no billing against the MBS). In other words, specialist clinics cannot be provided on an exclusively private basis.

This requirement can be satisfied by health services in a number of ways, including:

- operating parallel public and MBS-billed specialist clinics
- offering patients the choice to be treated publicly (i.e. with no billing against the MBS) in specialist clinics that are predominantly MBS-billed.

Patient consent

Responsibilities of States and Territories 25(d)

Under this National Healthcare Agreement, the States and Territories will:

(d) ensure that eligible persons who have elected to be treated as private patients have done so on the basis of informed financial consent.

It is a requirement that patients have the choice to be treated as either a public or private patient (i.e. with costs billed to Medicare). Eligible patients who choose not to have their services billed to Medicare should receive those services free of charge as a public patient.

Patients should be made fully aware of any financial implications associated with choosing to be treated privately. MBS-billed specialist clinic services provided by public hospitals are bulk billed against the relevant item number in the MBS, which means there is no charge to the patient. However, a co-payment may be charged by specialist medical practitioners providing services in their private rooms, which may be located at a public hospital under a tenancy arrangement.

The requirement for election to be a private patient applies even if the patient does not incur any out-of-pocket expenses and the full cost is bulk billed.

It is recommended that public hospitals display clear signage and institute appropriate guidelines and procedures that enable patients to make an informed choice to be treated as either a public or private (MBS-billed) patient.

Admitted and non-admitted patient care

Business Rule B2

Where care is directly related to an episode of admitted patient care, it should be provided free of charge as a public hospital service where the patient chooses to be treated as a public patient, regardless of whether it is provided at the hospital or in private rooms.

It is a requirement that patients must be able to access non-admitted care following an episode of admitted care as a public patient.

Referral pathways

Business Rule B3

Services provided to public patients should not generate charges against the Commonwealth Medicare Benefits Schedule:

(a) except where there is a third party payment arrangement with the hospital or the state/territory, emergency department patients cannot be referred to an outpatient department to receive services from a medical specialist exercising a right of private practice under the terms of employment or a contract with a hospital which provides public hospital services;

(b) referral pathways must not be controlled so as to deny access to free public hospital services; and

(c) referral pathways must not be controlled so that a referral to a named specialist is a prerequisite for access to outpatient services.

It is a requirement that patients referred from an emergency department to a public hospital specialist clinic cannot receive services that are billed against the MBS.

Referral pathways must not be manipulated to prevent patients from accessing a public service. A patient must be able to receive services free of charge as a public patient without a named referral.

Referral to specialist clinic services

Business Rule B5(b)

An eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless:

(b) the patient has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient.

It is a requirement that professional services rendered by a medical practitioner in a public hospital specialist clinic cannot be billed against the MBS unless:

- the patient has been referred to a named medical specialist who is exercising a right of private practice
- the patient chooses to be treated as a private patient.

It is recommended that public hospitals display clear signage and institute appropriate guidelines and procedures that enable patients to an informed choice to be treated as either a public or private (MBS-billed) patient.

Components of the specialist clinic service

Business Rule B6

Where a patient chooses to be treated as a public patient, components of the public hospital service (such as pathology and diagnostic imaging) will be regarded as a part of the patient's treatment and will be provided free of charge.

Pathology and diagnostic imaging procedures undertaken during a public specialist clinic appointment must be provided free of charge.

It is a requirement that only patients who elect to be treated as a private (MBS-billed) patient in a public hospital specialist clinic can receive MBS-billed pathology and diagnostic imaging services; otherwise these services are to be provided free of charge.

7. Implications of the Medicare Benefits Schedule

It is the responsibility of public hospitals and medical practitioners that provide MBS-billed specialist clinic services to comply with the current version of the MBS and any other supporting information issued by Medicare Australia.

The following requirements of the MBS should be considered:

Service eligibility for Medicare

Medicare benefits are payable only for clinically relevant services that are listed in the MBS (see G.1.2). A clinically relevant service is defined in the MBS as one which is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient.

Provider eligibility for Medicare

Specialist clinicians must meet eligibility criteria to be able to provide professional services that will attract Medicare benefits (see G.2.1). This includes recognition as a specialist or consultant physician as specified under the Health Insurance Act.

Medical practitioners registered in an approved specialist trainee program as specified under section 3GA of the Health Insurance Act can provide limited services that will attract Medicare benefits.

Provider numbers

Specialist clinicians providing professional services that can be claimed against the Medicare system must have a valid provider number for the location where the services are provided.

A provider number should not be used to claim against the MBS:

- without expressed permission from the medical practitioner
- for services that are not rendered by or on behalf of the medical practitioner (see G.12.2).

Referral of patients to specialist or consultant physicians

A valid referral must be received to enable a medical practitioner to bill specialist clinic services against the MBS (see G.6.1). A valid referral must be:

- documented in writing
- signed and dated by the referring practitioner; and
- received on or prior to the patient's first occasion of service.

It is important to note that referrals are time limited.

Medicare Australia has provided written advice stating that while a referral should be addressed to a named medical practitioner, the referral can be used by the patient to see a different medical practitioner provided that both medical practitioners have equal qualifications in the same discipline, operate in the same clinic and can access the patient's medical record. However, this arrangement does not apply to services that are billed against items 132 and 133 of the MBS.

Billing procedures

The specific billing procedures required by Medicare Australia should be met. Where services are bulk billed, the medical practitioner accepts the relevant Medicare benefit as full payment for the service and additional fees cannot be raised against the patient (see G.7.1).

Provision of medical services

Medical services that are billed against the MBS must be rendered by, or on behalf of, a medical practitioner.

In the case of the latter, G.12.2 specifies that services rendered on behalf of a medial practitioner must be billed in the name of the medical practitioner who is then required to provide supervision and accept full responsibility for the service.

Supervision

Where medical services are rendered on behalf of medical practitioners, it is the responsibility of the medical practitioner to provide supervision. The supervising medical practitioner need not be present for the entire service; however they must have direct involvement in at least part of the service (see G.12.2).

Maintenance of records

It is the responsibility of medical practitioners to maintain adequate and contemporaneous records of all services attracting a Medicare benefit payment (see G.15.1).

8. Remuneration models

In broad terms, there are two main remuneration models for MBS private practice arrangements in Victorian public hospitals:

- **100 per cent donation model**
- **100 per cent retention model.**

A third model, in which there is an agreement between the medical practitioner and the public hospital to share the revenue generated through the MBS, is not commonly used in Victorian hospitals.

The decision about which model to employ must occur in agreement between public hospitals and medical practitioners.

Public hospitals and medical practitioners may need to seek their own legal, financial and industrial advice before entering into an agreement.

100 per cent donation model

The 100 per cent donation model is also referred to as the '100 per cent payment over' model by the Australian Tax Office (ATO).

Under the 100 per cent donation model, all of the revenue generated by the medical practitioner through the MBS is paid over to the public hospital as a condition of employment. The medical practitioner is paid a salary by the hospital.

A proportion of the MBS revenue generated is held in a special purpose fund according to the medical practitioner's craft group. Uses of these funds are discussed on page 15. The remaining MBS revenue is for discretionary use by hospital management to cover the operational costs of the clinic.

To support the taxation process, health services are required to provide medical practitioners with timely information on MBS revenue earned and paid over to the hospital (see page 14).

The Victorian Government website http://archive.health.vic.gov.au/archive2011/privatepractice/ contains a detailed departmental communiqué on the 100 per cent donation model, including advice received by the Australian Medical Association (AMA) Victoria from the Health Insurance Commission and the ATO Class Ruling CR2005/26.

100 per cent retention model

Under this model, the medical practitioner retains all of the revenue generated through the MBS. For example, visiting medical officers (VMO) and medical practitioners may provide specialist services in their private rooms or salaried doctors may provide MBS-billed services in their own time.

Specialists operating under the 100 per cent retention model are not paid by the hospital for this work. The public hospital usually negotiates a facility fee with medical practitioners under this model to cover the costs of the clinic to the hospital.

9. The benefits and costs of MBS specialist clinics

In establishing a business case for MBS specialist clinics, health services should consider the likely benefits and costs of the clinics.

The following section outlines potential benefits and costs of MBS specialist clinics, including those specifically associated with the two main remuneration models, to support health services' decision making. The information presented was collected from senior representatives of a number of Victorian health services, based on their experience in establishing and maintaining MBS-billed clinics.

However, it is unlikely that the costs and benefits of MBS specialist clinics will be universally applicable to all public hospitals. In deciding to establish MBS specialist clinics, health services should consider whether, and to what extent, the following benefits and costs apply to their individual circumstances.

General benefits and costs

The following general benefits are associated with the establishment of MBS-billed specialist clinics:

- Recruitment and retention of highly skilled medical practitioners who may not otherwise practice in a public hospital or in a particular catchment area. This enables public hospitals to better meet the demand for specialist services, provides improved patient choice and increases training opportunities for junior medical staff.
- Variation in the remuneration models under which medical practitioners can provide MBS specialist clinic services, which allows flexibility of working arrangements.

The following general costs for public hospitals are associated with the establishment of MBS-billed specialist clinic services:

- Human resource and legal costs associated with the negotiation of an arrangement between a medical practitioner and the public hospital for the provision of MBS specialist clinic services.
- For patients who attend multiple specialist clinics, differences in the operation and physical location of VACS and MBS-billed clinics could present some difficulties unless clear directions are provided to patients.
- The MBS schedule fee is based on the cost of providing medical treatment only. Therefore, MBS specialist clinics are unlikely to be cost-effective if patients fail to attend their appointment and if the clinic is not fully booked. It is recommended that public hospitals consider the impact of patient attendance rates and appointment scheduling in the planning and establishment of MBS-billed specialist clinics.

Benefits of the 100 per cent donation model

Benefits of the 100 per cent donation model for health services include that:

- The ATO has sanctioned the 100 per cent donation model as specified in Class Ruling 2005/26. The class ruling states that full-time salaried medical practitioners employed under this model are required to report all MBS revenue earned against their provider number to the ATO; however, they are entitled to claim a deduction that is equal to the gross revenue paid over to the hospital. This results in a nil income tax effect.

- Revenue held in a special purpose fund can be used for the payment of:
  - work-related expenses of medical and related staff employed by the health service in accordance with the Craft Special Purpose Agreement entered between the practitioner and health service
  - expenses relating to training and education of medical staff in accordance with the Craft Special Purpose Fund Agreement entered between the practitioner and health service
  - expenses relating to training and education undertaken by medical and nursing students, postgraduate medical and nursing staff and paramedical staff which are not generally provided by the health service
  - salaries of staff of the health service who are wholly engaged in medical research relevant to participating practitioners within the group
  - expenses relating to the purchase of equipment by or on behalf of the health service or a contribution towards the purchase in whole or part of equipment and ancillary technology, items or materials to be used in medical treatment, diagnosis or research.

The use of special purpose funds should be clearly outlined in an agreement between the contributing medical practitioner and the employing public hospital. Medical practitioners' ability to contribute to decision making around the use of special purpose funds provides an incentive for the operation of specialist clinics under this model.

Costs of the 100 per cent donation model

Costs of the 100 per cent donation model for health services include that:

- It is the responsibility of public hospitals to indemnify medical practitioners working under the 100 per cent donation model. However, salaried medical practitioners employed by a public hospital with a right of private practice who are providing MBS-billed specialist clinic services under the 100 per cent donation model are covered by the Victorian Managed Insurance Authority (VMIA) Medical Indemnity Master Insurance Policy issued to the public hospital. (Further information about medical indemnity for MBS-billed specialist clinics is provided on page 17).
- The public hospital is required to provide medical practitioners operating under the 100 per cent donation model with clinical facilities, and access to necessary diagnostic and medical equipment. Associated costs to public hospitals may include the provision and maintenance of:
  - office space including utilities
  - business equipment (e.g. information and communication technology)
  - off-the-shelf consumables
  - patient transport
  - interpreting services
  - cleaning and sterilisation of equipment
  - equipment loan services.
- The public hospital is required to provide and meet the cost of allied health, nursing and administrative support for the specialist clinics operating under the 100 per cent donation model.
- Health services have reported that MBS-billed specialist clinics place significant demands on clerical staff in particular. Dedicated administrative support for MBS-billed specialist clinics should therefore be considered by public hospitals.

- The administration of MBS-billed specialist clinics under the 100 per cent donation model is managed by the public hospital. Associated costs relate to:
  - patient record management
  - referral management to ensure referrals are valid and active
  - triage
  - booking and scheduling patient appointments
  - billing processes to ensure all necessary information is included and accurate before it is submitted to Medicare Australia.
- Billing against the MBS is a manual process for the majority of Victorian public hospitals. This places a significant time and administrative burden on clerical staff in particular.
- A move to an electronic system will reduce the administrative burden on hospital employees in the longer term, assist data collection and improve health services' financial management of MBS specialist clinic services.
- Health services have reported that providing clerical staff with specific training to manage MBS billing and other administrative processes is beneficial.

Benefits of the 100 per cent retention model

Benefits of the 100 per cent retention model for health services include that:

- Medical practitioners operating under the 100 per cent retention model may be responsible for independently employing their own nursing and administrative staff, and managing billing against the MBS. In some health services, medical practitioners working under this model are also responsible for managing the patient record. The 100 per cent retention model may therefore reduce the administrative burden on the public hospital.
- Medical practitioners operating under the 100 per cent retention model can only be indemnified for liability arising from medical negligence under their own medical indemnity insurance policies. In other words, it is not the responsibility of public hospitals to indemnify medical practitioners operating under this model.
- Public hospitals may negotiate a fee with medical practitioners operating under the 100 per cent retention model to cover the costs of the clinic to the hospital. Fees may relate to:
  - provision of office space including utilities
  - management of patient records
  - interpreting services.

Public hospitals should consider reviewing these fees on an annual basis to account for increases in the cost of the provision of health care.

The information collected from health services did not identify any specific costs to public hospitals under this model.

10. Medical indemnity for MBS-billed specialist clinics

The VMIA Medical Indemnity Master Insurance Policy (1 July 2010 to 1 July 2011) definition of an insured person includes:

Victorian Managed Insurance Authority (VMIA) Medical Indemnity Master Insurance Policy

Employees of the health service or organisation named in the Schedule whilst:

(a) providing health care services to public patients of the health service or organisation;

(b) providing health care services to private patients of the health service or organisation where such health care services were provided by the employee in that employee's capacity as an employee of the health service or organisation;

(c) providing health care services to patients of the health service or organisation who are non-Australian residents;

(d) providing advice to a Victorian Public Health Services about the treatment of a patient of that Victorian Public Health Service;

but does not include any employee who at the time of the incident was required to be registered pursuant to the *Health Practitioner Regulation National Law (Victoria) Act 2009* but was not so registered.

Registered medical practitioners or other natural persons whilst providing health care service to patients of the health service or organisation named in the Schedule in accordance with the exercise of a right of private practice granted to the registered medical practitioner in his or her capacity as a fulltime or part-time employee of the health service or organisation provided that the terms of the registered medical practitioner's employment contract require the registered medical practitioner to:

(a) remit all or part of the fees earned in respect of such patient to a Dillon Fund, special purpose fund, trust or like arrangement established by or in conjunction with the employing health service or organisation; or

(b) remit all of the registered medical practitioner's income to the employing health service or organisation.

The VMIA Medical Indemnity Master Insurance Policy states that registered medical practitioners exercising a right of private practice who remit all or part of the fees earned to the employing public hospital do not bear liability for medical negligence under their own medical insurance policies. In other words, salaried medical practitioners employed by a public hospital with a right of private practice who are providing MBS-billed specialist clinic services under the 100 per cent donation model are covered under the VMIA Medical Indemnity Master Insurance Policy.

Medical practitioners operating under the 100 per cent retention model are **not** covered by the policy and therefore need to rely on their own insurance.

Appendix one: Links to relevant documents and further information

Australian Tax Office Class Ruling CR2005/26
http://law.ato.gov.au/atolaw/browse.htm?locid=CLR

Medicare Benefits Schedule
http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-benefits-schedule-MBS-1

National Healthcare Agreement
http://www.coag.gov.au/intergov_agreements/federal_financial_relations/index.cfm

Health Insurance Act 1973
www.austlii.edu.au/au/legis/cth/consol_act/hia1973164/

Victorian Department of Health hospital circulars
http://www.health.vic.gov.au/hospitalcirculars/

- Circular 12/2010 - Compliance with obligations for MBS-billed specialist clinics
- Circular 18/2009 – National Healthcare Agreement
- Circular 22/2006 – Australian Health Care Agreement: Compliance with charges for patients other than public patients
- Circular 34/2004 – Australian Health Care Agreement: Compliance with the Medicare principles
- Circular 33/2003 – Australian Health Care Agreement: Compliance with Medicare principles

Victorian Department of Human Services Communiqué – 8 June 2005: Rights of private practice within the Victorian Public Health System
http://archive.health.vic.gov.au/archive2011/privatepractice/

Victorian Department of Human Services, Client services through Medicare: Opportunities and considerations for community health services, February 2009
http://www.health.vic.gov.au/communityhealth/downloads/

Victorian Department of Human Services, Guidelines for the identification and establishment of specific purpose funds
http://www.health.vic.gov.au/accounts/spfund.pdf

Victorian Managed Insurance Authority (VMIA) Medical Indemnity Master Insurance Policy (1 July 2010 to 1 July 2011)
http://www.vmia.vic.gov.au/skillsEDIT/clientuploads/48/Medical%20Indemnity%20Master%20Policy%20Wording%202009-2010_1.pdf

Victorian public hospital specialist clinics strategic framework
www.health.vic.gov.au/outpatients